



Andrea Simons, DPM
Davina Cross, DPM
Jeffrey Lin, DPM
13765 S. Sedona Parkway, Lansing, MI 48906
(517) 668- 6166

Patient History

Today's Date: _____

Date of Birth: _____ Social Security #: _____

Name: _____
(First) (MI) (Last)

Prefers to be called _____

Address: _____
(Street)

(City) (State) (Zip)

Home Phone: _____ Cell Phone: _____

Work Phone: _____ Preferred Phone: _____

Email: _____

Employer: _____ Occupation: _____

Marital Status: _____ Spouse's name: _____

Guardian's name (if patient is a minor): _____

Address (if different from above): _____
(Street) (City/State/ZIP)

Person to contact in case of an emergency: _____

Relationship to patient: _____ Phone: _____

Address: _____
(Street)

(City) (State) (Zip)

Referred By: _____

(Please Circle)

Race: African American, American Indian/Alaskan, Native Asian, Pacific Islander, White, **Other/Decline to Disclose** **Ethnicity:** Hispanic/Latino, Non-Hispanic/Latino, **Decline To Disclose**

Birth Sex: ___ Male ___ Female **Identifies as:** ___ Male ___ Female ___ Other

What is your foot or ankle problem? _____

When did the problem start? _____

How have you treated the problem? _____

Weight: _____ Height: _____ Shoe Size: _____

Are you in: () good health () fair health () poor health

Are you prone to prolonged bleeding or healing difficulties? () yes () no

Do you bruise easily? () yes () no

Primary Care Physician's name and address: _____

Last time you saw your Primary Care Physician _____

What medications are you currently taking? (If you have a list with you, we can copy the list.)

Name	Dose	Frequency

Are you allergic to any medications? _____

If yes, which ones? _____

Preferred Pharmacy? _____

Are you pregnant? yes no
 Do you smoke? yes no If yes, how much? _____
 Do you drink alcohol? yes no If yes, how much? _____
 Do you take any illicit drugs? yes no If yes, which ones? _____

Past Medical History (Do you currently or have you ever had any of the following):

Heart Disease	<input type="checkbox"/>	Asthma	<input type="checkbox"/>	High Cholesterol	<input type="checkbox"/>
Neuropathy	<input type="checkbox"/>	Anemia	<input type="checkbox"/>	Stomach ulcer/GERD	<input type="checkbox"/>
Hypertension	<input type="checkbox"/>	Stroke	<input type="checkbox"/>	Kidney Disease	<input type="checkbox"/>
Bleeding Disorder	<input type="checkbox"/>	Blood Clot	<input type="checkbox"/>	Liver Disease	<input type="checkbox"/>
Pneumonia	<input type="checkbox"/>	Epilepsy	<input type="checkbox"/>	Thyroid Disease	<input type="checkbox"/>
Venereal Disease	<input type="checkbox"/>	Arthritis	<input type="checkbox"/>	Pregnancy	<input type="checkbox"/>
HIV	<input type="checkbox"/>	Other	<input type="checkbox"/>	Cancer	<input type="checkbox"/>
Diabetes	<input type="checkbox"/>	Peripheral arterial disease/ Poor Circulation	<input type="checkbox"/>	Type: _____	

Diabetic History:
 Type: _____ Date of Onset: _____
 Complications due to Diabetes? _____

Do you have a family history of:

Diabetes	<input type="checkbox"/>	Blood clots/Bleeding Disorder	<input type="checkbox"/>
Heart disease	<input type="checkbox"/>	Problems with anesthesia	<input type="checkbox"/>
Cancer	<input type="checkbox"/>	Hypertension	<input type="checkbox"/>
Peripheral Arterial Disease/Poor Circulation	<input type="checkbox"/>	Other	<input type="checkbox"/>

Past Surgical History: _____

Problems with anesthesia? _____

Is there anything else you feel we should know? _____

I hereby give permission to Dr. Andrea Simons, Dr. Davina Cross, or Dr. Jeffrey Lin to treat and/or photograph my foot.

Date: _____

 Signature of Patient or Guardian



Insurance Information

Do you have a copay? Yes or No If yes, fill in amount here \$_____

<u>Primary Insurance Company</u>	
Policy Holder	SSN#
Your Relationship to the Policy Holder	
Enrollee ID# or Medicare Claim Number	Group #
Subscriber's Employer	
Policy Holder's Birthdate	
<u>Secondary Insurance Company</u>	
Policy Holder	SSN#
Your Relationship to the Policy Holder	
Enrollee ID#	Group #
Subscriber's Employer	
Policy Holder's Birthdate	

Release and Assignment of Benefits

I hereby authorize the release of any medical information necessary to process my insurance claim. I authorize payment to be made directly to Looking Glass Foot & Ankle Center, P.C., tax ID # 27-2516761. I have been provided with a copy of the Looking Glass Foot & Ankle Center Financial Policy and understand that I am financially responsible for any and all balance(s) not covered by insurance carriers or out-of-pocket expenses at the time of service.

Signature

Date



Patient Name: _____

_____ Date of birth _____

(Please Print)

PAYMENT

I acknowledge that I have been offered the Financial Policy and I acknowledge it is my responsibility to pay for any services I receive from Looking Glass Foot and Ankle Center.

Signature

Date

MEDICARE PATIENTS ONLY

I authorize and request that payment of authorized Medicare benefits be made to Looking Glass Foot and Ankle Center on my behalf for any services furnished to me by a provider of Looking Glass Foot and Ankle Center.

Signature

Date

DO YOU HAVE AN ADVANCED DIRECTIVE? Yes No

For more information regarding Advanced Directives please visit www.caringinfo.org

LOOKING GLASS FOOT AND ANKLE CENTER NOTICE OF PRIVACY PRACTICE

I acknowledge that I have been offered the Looking Glass Foot and Ankle Center Notice of Privacy Practices

Patient Name (please print)

Signature

Date

COMMUNICATION OF YOUR PROTECTED HEALTH INFORMATION

If you want us to speak with another individual **including your primary care physician** about your care, please list their name, relationship to you, and phone number:

Name

Relationship

Phone Number

Signature

AFTER HOURS CARE For emergencies call our office phone 517-668-6166 and follow the prompts to reach the doctor on call or visit your nearest Urgent Care.